Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 25 July 2023

Subject	Maternity and Neonatal Safety Report
Supporting TEG Member	Chris Morley, Chief Nurse
Author	Ali Brodrick, Head of Midwifery, Laura Rumsey, Interim Midwifery Director, Andrea Galimberti, Clinical Director and Sue Gregory, Operational Director
Status[1]	A

PURPOSE OF THE REPORT

To present a monthly safety and quality overview of Jessop Wing Maternity and Neonatal Services to the Board of Directors reporting period of 1st May-31st May 2023.

The report will provide an oversight position on:

- Perinatal Quality Surveillance Model (PQSM)
- Health Care Safety Investigation Branch (HSIB) investigations
- Serious Incidents (SI)
- Training
- Maternity Dashboard
- Maternity Safety Champions activities
- Workforce: Maternity and Neonatal Staffing
- Care Quality Commission (CQC) Review
- Clinical Negligence Scheme for Trusts (CNST) Year 5
- Saving Babies Lives Care Bundle version 3 (SBLv3)
- The Three-Year Delivery Plan for Maternity and Neonatal Services

KEY POINTS

Key Risks

No new risks have been identified this month; therefore, the key risks remain:

- That a maternity specific information system is not in place at the Jessop Wing. Work is currently underway in preparation for the implementation of the Maternity Module as part of the Oracle Cerner Electronic Patient Record, there has been good engagement from all maternity staff contributing to the future state review and localisation workshops.
- The work on sharing historical Perinatal Mortality Review Tool (PMRT) reports not shared with families continues as the priority focus. A comprehensive tracker is reported to triumvirate weekly to monitor progress and trajectory.

Improvements

Areas of improvement as highlighted in previous report:

- The Jessop Wing is currently rated as 'requires improvement' by the Care Quality Commission (CQC) and a revised action plan has been embedded into the Maternity Improvement Programme. The service is now preparing an application to the CQC to have the conditions on the Trust's registration relating to

Maternity lifted.

- There are currently 10 open SI's the aim is to keep this number below 10, by ensuring that there is prompt thorough investigation of Serious Incidents.
- ATAIN data-(Avoiding Term Admissions into Neonatal Units) the Jessop Wing has a sustained term admission rate to the Neonatal Unit (NNU) as a percentage of live births below the local target of 5% (national aim <6%). For the year 2022/23 the rate was 4.2%
- Consultant obstetric recruitment continues to improve with 2 fixed term consultants now in post, 2 further members of staff are expected to start in the coming months.
- The combined Friends and Family Score for Maternity continues to be reported at over 90% showing considerable improvement on April 2022 position of 69%.

Improvements previously reported which continue to be embedded:

- The use of the electronic SitRep (Situation Report) allowing enhanced oversight of staffing, women awaiting Induction of Labour (IOL), activity and acuity in Maternity and Neonatal Services. Twice daily position now reported.
- Staff retention plan is being implemented to support staff to stay and grow. Pastoral support lead is supporting early career midwives, internationally recruited midwives and Maternity Support Workers (MSW).
- Birmingham Specific Obstetric Triage System (BSOTS) is now embedded on labour ward, work is on-going to improve the timeliness of the 1st assessment when women arrive in triage.

National Maternity Issues

- The Three Year Delivery Plan for Maternity and Neonatal Services has been launched and incorporates the Ockenden Immediate and Essential Actions (IEAs).
- Year 5 Maternity Incentive Scheme has been published and work has started in the 10 elements, all of which are being embedded as part of the Maternity Improvement Plan.

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ Tick as appropriate
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Create a Sustainable Organisation	✓
6	Deliver Excellent Research, Education and Innovation	✓

RECOMMENDATIONS

The Board of Directors are asked to receive and discuss the contents of this report.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	12.07.2023	Y
Board of Directors	25.07.2023	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

1. REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors, monthly, of present or emerging safety concerns or activity to ensure safety with a two-way reflection of *Ward To Board* insight across the multi-disciplinary, multi- professional maternity services team. The information within the report will reflect actions in line with Three Year Delivery Plan for Maternity and Neonatal Services and progress made in response to any identified concerns at provider level.

- Aligned with the Perinatal Quality Surveillance Model (PQSM) Jessop Wing, maternity and neonatal services are required to report information outlined in the data measures proforma monthly to the Board of Directors (appendix 1). The report covers the period May 2023.
- The report can also provide evidence towards year 5 of the NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

As previously discussed, the Three Year Delivery Plan for Maternity and Neonatal Services was published by NHS England on 31st March 2023 with the aim of making maternity care safer, more personalised and equitable, outlined in four high level themes. The Three Year Delivery Plan provides maternity services with one improvement plan with the Integrated Care Board (ICB) responsible for regional assurance. The expectation is that reporting on the Ockenden Immediate and Essential Actions will be replaced by the Three Year Delivery Plan. A meeting between providers and the LMNS on the 20th June 2023 agreed one reporting system, this will ensure equitable assurance across all Trusts. The final plan and expected deliverables will be aligned with the Maternity Improvement Plan and will be shared with the Board.

2. PERINATAL MORTALITY

NHS England set out a national ambition to halve the rates of stillbirth, neonatal deaths, maternal deaths, and brain injuries during birth by 2025, (from a 2010 baseline).

All stillbirth and neonatal deaths are reported through the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) PMRT process.

Following completion of the serious incident backlog, historical Perinatal Mortality Review Tool (PMRT) cases are now the priority and the position for outstanding historical cases from 1st January 2021-5th December 2022 will be reported here.

As previously discussed, reporting of PMRT cases has been strengthened to include both booked at Sheffield cases and in/ex-utero transfers. This is to fully describe the workload required of the Jessop Wing teams to clear all elements of the PMRT caseloads, both current and historical. Validation of the locally held tracker against MBBRACE has revealed additional cases that have been added. As discussed previously the data has been altered to now include publication rather than report completed as this is the level of evidence required by the LMNS, MBBRACE and NHSR.

- Of the 2021 PMRT cases, there were 75 open cases eligible for reports and of these 44 were booked at Sheffield. 53 still require reports to be published, 36 of which are Sheffield booked cases. Twenty two cases are now closed.

- Of the Jan – May 2022 cases, there are 28 open cases eligible for reports and of these 19 were booked at Sheffield, 24 still require reports to be published, 19 of which are Sheffield booked cases. Four cases have been closed.

- Of the May – December 2022 caseload, there are 53 open cases eligible for reports and of these 30 were booked at Sheffield, 5 still require reports to be published, 2 of which are Sheffield Cases.

- Of the current PMRT 2023 caseload, there are 30 open cases eligible for reports and of these 21 were booked at Sheffield and none of these have breached the 6 month reporting deadline. 29 still require reports to be published (21 of these are Sheffield booked cases).

Progress of all PMRT cases is maintained on a live tracker and the triumvirate are appraised of progress weekly. The agreed timescale for completion of all historical PMRT cases is now October 31st 2023. CNST Year 5 requires a quarterly, PMRT tool generated report to be discussed with the Maternity Safety Champions and submitted to the Trust Executive Board. The first of these reports will be presented along with August's Maternity and Neonatal Safety Report.

2.1 PMRT figures

Between 01/05/2023 and 31/05/2023 Jessop Wing reported 2 stillbirths and 4 neonatal deaths (NND) to MBRRACE-UK.

- 1 stillbirth occurred at 28 weeks with known early onset placental profusion complications.
- 1 stillbirth occurred at 24 weeks, with known early onset growth complications.
- 1 NND occurred at 26 weeks following complications post birth
- 1 NND at aged 10 days, of a baby born extremely premature at 24+1
- 1 NND at 30 weeks of a baby known to have inutero complications affecting chances of survival.
- 1 NND occurred at 22 weeks of a baby transferred in from another maternity unit.

3. HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND MATERNITY SERIOUS INCIDENTS (SI'S)

HSIB conducts investigations into all maternal deaths of women while pregnant or within 42 days of birth. All intrapartum stillbirths, early neonatal deaths (0-6 days) born at term and all cases of severe brain injury (HIE) diagnosed within first 7 days of life.

3.1 HSIB investigations

Themes and trends relating to all HSIB investigations are shared at STH quarterly review meetings, the next meeting will be held 28th June 2023.

3.2 HSIB Investigation active case progress update

We have referred 1 case of a maternal death to HSIB for the month of May 2023.

In total there 3 open cases currently being investigated by HSIB

3.3 Coroner's Inquests including Reg 28 made directly to Trust

There have been no inquests or Regulation 28 notices received during May 2023.

3.4 Maternity Serious Incidents

6 serious incidents were declared and reported to the Trust Serious Incident Group (SIG) in May 2023. All incidents have been notified to the Integrated Care Board (ICB) and are being investigated within the department.

Serious Incidents continue to be reported to the South Yorkshire and Bassetlaw (SYB) LMNS Quality and Safety Group and up through Yorkshire and the Northeast (NE) Perinatal Quality Surveillance Group (PQSG) for regional oversight.

Serious Incident Investigations reported to SIG May 2023

Incident description
Delay in expediating birth of a baby born at full term. Baby born in poor condition.
Sudden collapse of a baby in the Neonatal Unit shortly after birth following a significant bleed from the umbilical cord site. Baby responded quickly to treatment and condition stabilised.
Return to theatre for laparotomy and exploration of abdominal bleeding following an elective Caesarean Section.
Neonatal death of a baby born at 25+6 weeks, it was felt that earlier birth may have improved survival chances.
A baby was born in poor condition after a placental abruption and required therapeutic cooling. Initially the case met the criteria for HSIB reporting however following further review of the baby's condition the case was rejected by HSIB and a Serious Incident investigation was commenced.
Maternal death occurring at 13 days post birth, following readmission to hospital. Case has been referred to HSIB for external investigation and notified to MBRRACE-UK and ICB for information only.

Progress of Serious Incident Investigations

- 10 Serious Incident investigations in progress at time of the report writing.
- 0 reports awaiting final approval from SIG
- 1 report has been approved by SIG in May 2023.

3.5 Maternity Serious Incident Investigation Trajectory

Serious Incident Status

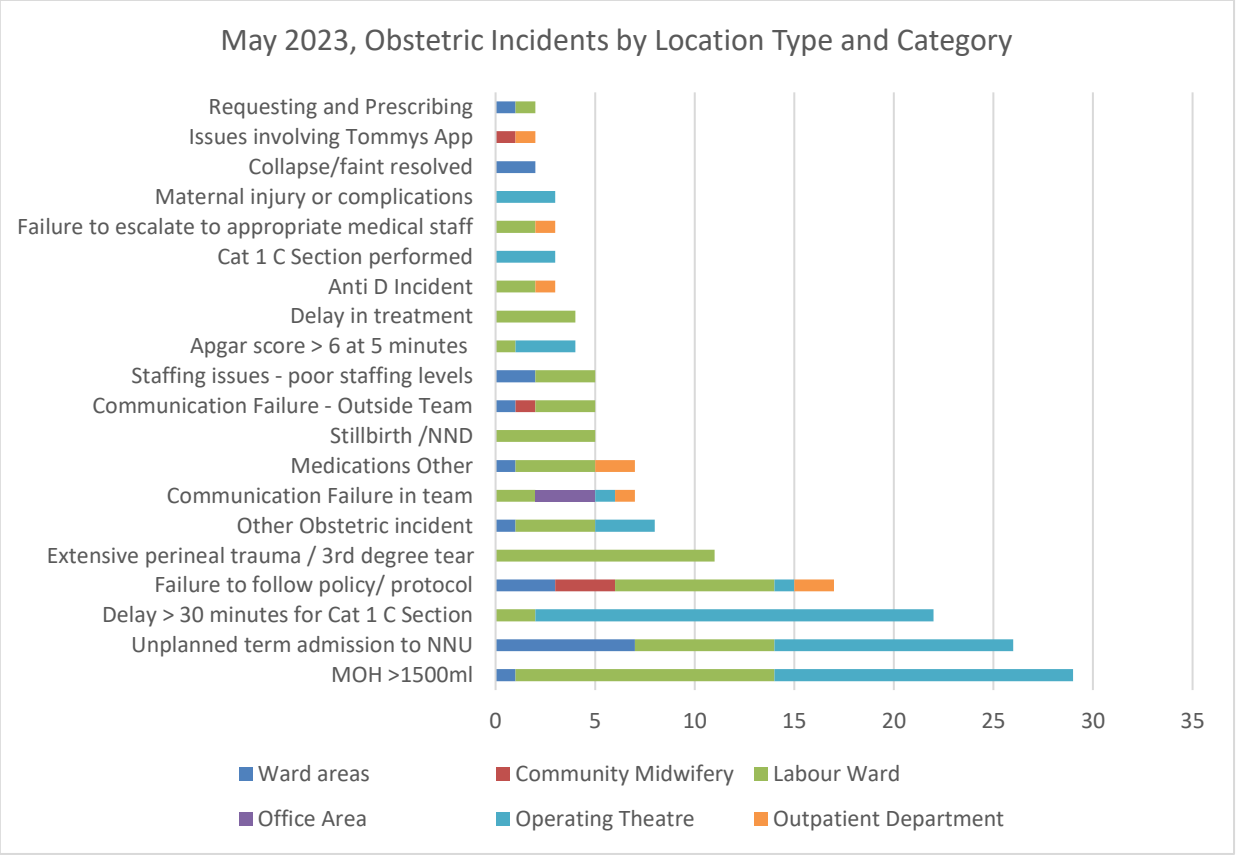
The table below shows that there are 10 open Serious Incident investigations.

New Serious Incidents reported in month	**5+1 HSIB**
Serious Incidents closed in month (*SIG approved subject to minor amends*)	**1**
Incidents in progress (*includes new Sis reported within the month*)	**10**
Out of internal reporting deadline	**0**
Out of external reporting deadline for ICB	**0**
Incidents with external deadline extensions.	**0**

3.6 Overview of Incidents reported in May 2023

- 233 maternity incidents were reported through the Datix incident reporting system during May 2023. Jessop Wing Labour Ward and Obstetric Theatres remain the highest reporting area with incidents associated to the outcomes of labour and birth**.** i.e. Major Obstetric Haemorrhage (MOH) (29), Delay in performing Category 1 Caesarean Section outside of the recommended 30 minute timeframe (22) and third degree perineal tears (11). In addition, there were 26 unplanned term admissions to NNU with 12 cases admitted from the Obstetric Theatre. All unanticipated admissions are reviewed as part of the ATAIN improvement work to identify if the admission could have been avoided.

Incidents reported by location, type and category May 2023



- The incidence of MOH shows an increase to 29 as compared to 13 reported last month. Focused work continues in this area with cases reviewed by a multi-disciplinary team

3.7 Actions being taken to address issues arising from Serious Incidents

The Maternity and Neonatal service are monitoring all actions from Serious Incidents reported from 2021 onwards to ensure that learning is embedded into practice. The cleared backlog of serious incident investigations has resulted in the opportunity to perform a human factors thematic analysis and action plan to ensure that the resultant actions have the greatest impact on learning and safety. The Quality and Safety team will be working with the Corporate Governance team to understand how this work can be conducted in line with the new PSIRF framework whilst retaining the requirements of CNST Year 5 for actions following serious incidents to be reviewed by the Trust Board.

3.8 Incident Grading of Harm / Impact –for all incidents reported in May 2023

Row Labels	1 No Harm / Impact	2 Low Harm / Impact	3 Moderate Harm / Impact	4 Severe Harm/ Impact	2 Catastrophic	Total
May 2023	45	150	35	2	1	233

Severe Harm Incidents:

- 2 severe harm incidents were reported in May 2023. The incidents involved the care for a mother and her baby following admission to hospital and diagnosis of a placental abruption. The mother required treatment for a major obstetric haemorrhage and was admitted to ICU for a higher level of care and monitoring. The baby was born in poor condition and required therapeutic cooling. The case met the HSIB referral criteria however following review by HSIB the case was rejected for investigation and an internal Serious Incident investigation was commenced.

Catastrophic Harm Incidents:

- 1 catastrophic harm incident was reported following a maternal death which occurred 13 days after birth. Following discharge home the mother became suddenly unwell in the postnatal period and was admitted to ITU. Multi professional care was provided however the woman did not respond to treatment and sadly died.

Moderate Harm Incidents by Type

Moderate Harm Incidents by Type May 2023	Patient incident
Apgar score less than 6 at 5 minutes of age	3
Birth injury	1
Bladder trauma and faecal incontinence	1
Fourth degree tear	2
Major Obstetric haemorrhage >1500ml	3
Maternal injury or complications	3
Shoulder dystocia	1
Stillbirth /NND	3
Unplanned term admission to JW – Neonatal Unit.	16
Unplanned transfer of patient to HDU ITU	2
Total	35

4. TRAINING DATA – May 2023

Training compliance for Trust mandatory training remains static and under the 90% threshold. Staffing pressures and the amount of training time required is still affecting release of staff. The compliance for PROMPT and fetal monitoring which are key components of the Maternity Incentive Scheme have both declined again this month and has not yet met the 90% threshold required. A change to the competency assessment process for fetal monitoring has been developed to improved compliance. Focused efforts continue and a non-compliance report continues to be shared with the senior midwifery team and the clinical director.

Mandatory training maternity services MAY 2023	Compliance 90%	Change from previous month
Conflict Resolution - Level 1	86.6%	+0.3%
Data Security and IG - Level 1	93.2%	-1.9%
Equality & Diversity: General Awareness - Level 1	97.2%	-0.4%
Fire Safety Theory - Level 1b	91.3%	-1.6%
Health, Safety & Welfare - Level 1	98.6%	-
Infection Prevention and Control - Level 2	89.4%	-1.9%
Moving and Handling - Level 1 (4 Yearly)	98.2%	+0.2%
Moving and Handling - Level 2b (1 Yearly)	78.1%	+4.8%
Adult Basic Life Support - Level 2a	74.2%	-5.8%
Neonatal Life Support - Level 2c	86.6%	-7.4%
Safeguarding Children & Young People - Level 1	93%	+2.6%
Safeguarding Children & Young People - Level 2	75%	+0.8%
Safeguarding Children & Young People - Level 3	71.7%	+0.7%
Safeguarding Vulnerable Adults - Level 2	86%	-10.1%
Safeguarding Vulnerable Adults - Level 3	0.9%	-
Mental Capacity Act - Level 2a	89.9%	+0.2%
Deprivation of liberty-level 2b	89..4%	-0.3%
Total MT compliance	82.4%	-1.0%

Maternity specific and CNST reportable	Compliance 90%	Change from previous month
Obstetric Emergency Drills (PROMPT)	83.4%	-2.8%
Fetal Monitoring	81.7%	-3.5%
Total Compliance	82.6%	-3.2%

5. JESSOP WING - MATERNITY DASHBOARD (October 22 – May 23)

The Jessop Wing Maternity Dashboard (Appendix 2) reflects data agreed regionally and nationally to assess the Trusts progress against various quality indicators. Data is validated monthly at the OGN Directorate Governance meeting. To provider a clearer analysis to Board of the outcomes and trends a revised dataset is in production, anticipated time frame for completion is September 2023.

Service improvement work is underway to increase the numbers of women being seen for booking by 10 weeks. Regionally the average for this metric in quarter 4 22/23 was 67% with rates ranging from 57.5%-83.6%.

Data for Labour Ward Assessment Unit (LWAU) shows that the target figure of 15 minutes for first review has been achieved again despite an increase in the number of admissions through LWAU during May 2023.

The readmission rate of 27 for May 2023 is higher than expected, a case note review is currently

underway and issues with data capture have also been identified.

6. NHS RESOLUTION (NHSR)

6.1 Maternity Incentive Scheme (MIS)

Year 5 MIS has been launched and work is underway to map the key deliverables and a clear timeframe for all evidence submissions and associated papers. Workstreams for each element are underway. The year 5 MIS standards include the same 10 maternity safety actions as referenced in previous years however the data and audit requirements have increased.

7. BOARD LEVEL SAFETY CHAMPIONS MEETINGS

The role of this group is to share and as necessary escalate locally identified issues to the board via the executive and non-executive board members who are the named Maternity & Neonatal Safety Champions.

A meeting took place on 22nd June 2023, feedback from safety champion walk rounds including visits to the neonatal unit and Community Midwifery was discussed. The following points in particular were noted:

Neonatal Unit

- Following previous Safety Champion feedback the unit now has a Ward Clerk to prevent nursing staff having to undertake administrative duties
- Whilst the vacancies in the nursing team are being filled, there is a need to train more staff to be 'Qualified in Specialty', the plans to increase training in this area were discussed at the Safety Champion meeting.

Community Midwifery

- The Midwife concerned felt that the women on her caseload get good continuity of care both antenatally and postnatally currently, but she is concerned that this would not be as good in the nationally proposed model of Continuity in Care was introduced. Confirmation that roll out of Continuity of Care in Sheffield is paused currently whilst core midwifery staffing levels are increased.
- The Midwife was appreciative of having access to a Bilirubin meter and felt it would be advantageous if the ratio of meters to midwives was increased. This is being explored further.
- The fairness of the current on call rota to cover Labour Ward at times of escalation was raised. Whilst better than it had been, she wondered if other non-community teams could also contribute to this rota. The Interim Midwifery Director is considering this issue.

The safety champion walk round is appreciated by staff who are happy to engage, it also continues to demonstrate for them one of the mechanisms forward to board reporting.

7.1 Learning from Incidents, Complaints and Claims

Learning from events continues to be disseminated through multiple formats to facilitate the widest dissemination of information across the services and disciplines. A focused piece of learning was highlighted in a previous report and further examples will be reported quarterly.

Formats for learning continue to include:

- Weekly Patient Safety Learning Newsletter, this includes QR codes for staff feedback and Guideline of the month.
- Safety Huddles undertaken daily and twice daily on intrapartum and antenatal areas where immediate safety learning from incidents is shared.
- Governance team members are allocated to all ward areas and visit to support ward managers in dissemination of learning and feedback. Closing the Loop format shared via closed Multi-

Disciplinary Team Face Book page and email.

- Open Triumvirate Briefing meetings to feedback learning from appropriate incidents, complaints, claims and Maternity Improvement Programme progress.

8. WORKFORCE

8.1 Midwifery Workforce

There continue to be vacancies in the midwifery workforce, however, RM and RN fill rates are predominantly greater than 90%. The incentive rate for midwifery staff continues to support this.

The first of the newly qualified midwives will start at the beginning October 2023, this cohort equates to 23.76 WTE. In addition there are 3 international midwives expected this year.

A number of on-going actions remain in place to maximise staffing into critical functions to maintain safe care for the women and their babies. It is preferable to have higher fill rates during the night-time when there is less support available from specialist midwives and managers.

Jessop Wing Fill Rates						
	March		April		May	
	Day	Night	Day	Night	Day	Night
Labour Suite	99.5%	91.1%	98.1%	93.9%	104%	95.6%
Rivelin	96.5%	95.3%	89.6%	100%	95.6%	73.9%
Norfolk	114.7%	134.2%	110.5%	95.7%	116.9%	89.2%
Whirlow	115.9%	142.0%	109.4%	94.9%	111.9%	88.5%
NICU	88.5%	88.6%	89.7%	86.8%	89.6%	89.3%

* Advanced Obstetric Care Unit(AOCU), Norfolk and Whirlow wards are using Registered Nurses (RN) alongside midwives to provide care for post-natal women and their babies.

Actions taken to support safe staffing are captured in the live Birth-rate Plus (BR+) web-based acuity tool. The BR+ acuity tool is used across Labour suite (Consultant led and Midwifery Led), the tool is currently being upgraded and the data for the antenatal ward (Rivelin), and the Postnatal wards (Whirlow and Norfolk) are currently not available all across all units. We are currently capturing the red flag data through datix as an alternative whilst the realtime acuity and activity information is unavailable.

Further initiatives to enhance the midwifery workforce have been included in previous monthly updates.

8.2 Obstetric Workforce

Consultants

Gaps:

Number of posts	Reason for gap	Resident Night Rota
4	Phased return – reduced clinical work with no resident nights	No

Recruitment:

- One vacancy due to resignation not replaced (no applicants)
- One approved post in Maternal Medicine Not recruited to.

Registrar Level

Current Gaps:

WTE	Level	Reason for gap	Labour Ward On Call
2	ST3+	Vacancies	Yes
2	ST1/2	Vacancies / LTFT Post holders	Yes

Mitigation:

- ST3+ - existing team being utilised to cover Labour Ward / On Call gaps at the detriment to gynaecology clinic/activity.

8.3 Neonatal Workforce

The neonatal unit (NNU) team continues to work toward compliance with the British Association of Perinatal Medicine (BAPM) standards. The Neonatal Operational Delivery Network (ODN) completed a workforce review which showed deficits in staffing. Significant progress continues with a number of appointments, including 12 newly qualified nurses expected to start in September/October 2023.

9. INSIGHTS FROM SERVICE USER ENGAGEMENT AND MATERNITY VOICES PARTNERSHIP (MVP) CO-PRODUCTION

The Maternity Service is actively involving the Sheffield Maternity Voices Partnership (MVP) in a variety of projects.

- As discussed previously work to rationalise the MVP workplan has been completed, a further meeting is taking place with the LMNS to ensure the work plan is appropriately financed to enable the extensive co-produced service improvement work to continue.

- MVP meetings are held bi monthly with the next meeting taking place on the 18th July 2023

10. CARE QUALITY COMMISSION (CQC)

As previously discussed the most recent CQC 'must do' and 'should do' actions have been included as part of the maternity improvement programme.

10.1 CQC escalations

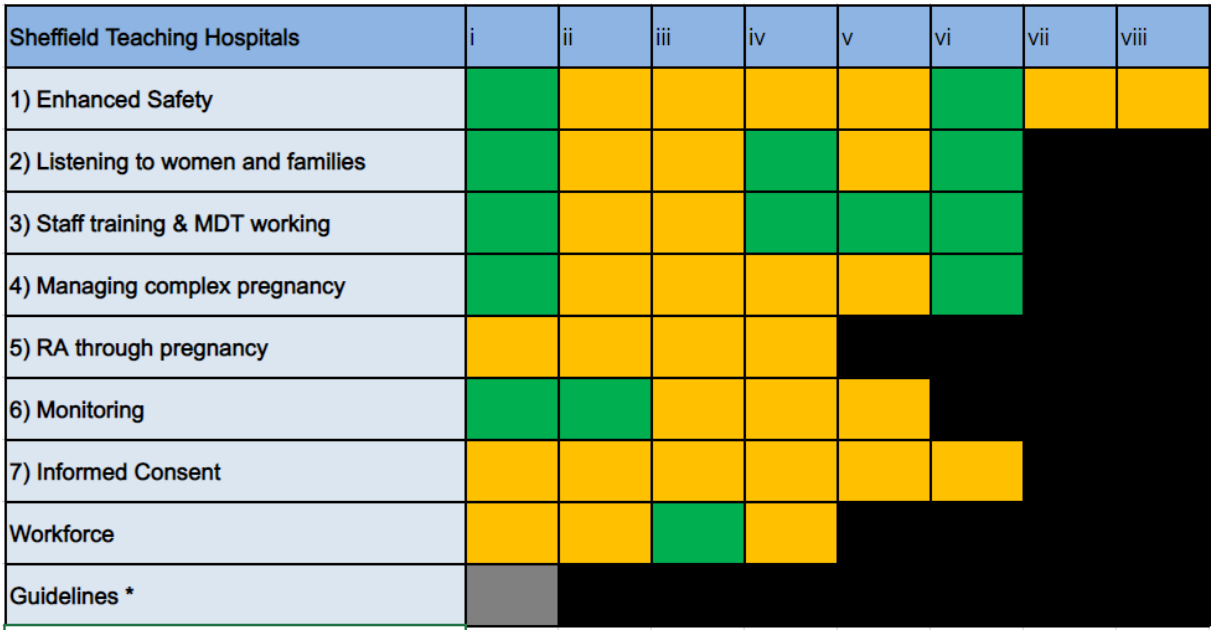
There have been no CQC escalations for May 2023.

11. OCKENDEN REPORT 2020 7 IMMEDIATE AND ESSENTIAL ACTIONS (IEA'S)

As discussed previously following the confirm and challenge in November 2022 the ICB fed back their findings on 2nd February 2023 which are presented in the table below. Each of the IEA'S below have a number of individual standards which require to be evidenced through audit.

Following the publication of the Three Year Delivery Plan for Maternity and Neonatal Services a

meeting took place on the 20th June 2023 and agreed that reporting of Ockenden would be incorporated within a single reporting matrix and alongside the Three Year Plan. The current audit requirements for Ockenden IEA's will be maintained until the changes are outlined and fully understood.



*The ICB were unable to rate guidelines during their visit

12. AVOIDABLE TERM ADMISSIONS INTO THE NEONATAL UNIT (ATAIN)

12.1 The National Ambition

In August 2017 NHS Improvement distributed a Patient Safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks.

12.2 Jessop Wing Transitional Care

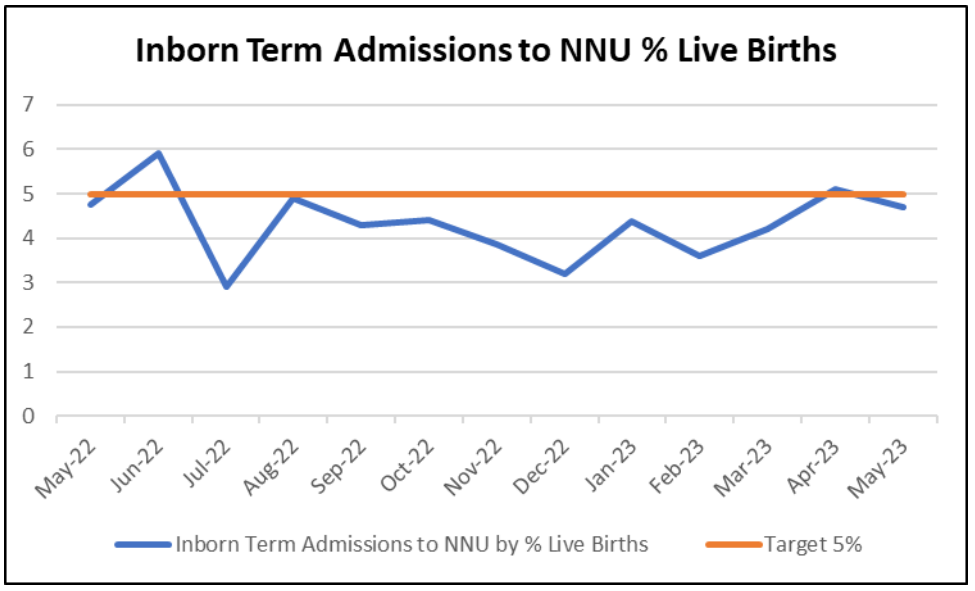
A weekly review of all term admissions is undertaken by the ATAIN team. Collated data is submitted monthly onto the electronic South Yorkshire and Bassetlaw (SYB) Local Maternity and Neonatal System (LMNS) ATAIN Quality Improvement dashboard. Actions are developed and agreed to address any themes highlighted. The action plan triangulates with actions and themes via other governance routes; Quality & Safety Meeting, HSIB, SI reports, CQC recommendations for term admissions. The National aim is to maintain <6% and the LMNS aim is <5%. For the year 22/23 the term admission rate to the neonatal unit was 4.2%

For May 2023 the term admission rate to the Neonatal Unit was 4.7%

Of the 23 term admissions in May 2023 11 were categorised as potentially avoidable/avoidable by the ATAIN multi-disciplinary team. 7/23 of the term admissions were discussed via the Patient Safety Review.

As discussed previously there are a number of ongoing actions to reflect themes and learning from ATAIN cases.

Year 2022 – 2023 ATAIN data



13. NHS ENGLAND PERINATAL CULTURE AND LEADERSHIP PROGRAMME

This programme is built around the perinatal quadrumvirate, or 'quad', group of senior leaders (The Midwifery Director, Operations Director, Clinical Director and Neonatal Clinical Lead) with the aim of nurturing a positive safety culture, enabling psychologically safe working environments and building compassionate leadership to make work a better place to be and is included in the requirements for CNST Year 5. The programme includes a series of workshops and action learning sets and provides dedicated time to the quadrumvirate to work and learn together, accompanied by individual time to focus on personal development. The final component of this is the SCORE Culture Survey, an independently facilitated programme with team and quad debriefing sessions to co-design the cultural improvement actions identified. The data collection phase has now been completed with the Jessop Wing Maternity and Neonatal teams achieving an 83% response rate. Over the next 4 months, the quad and team debriefing sessions will take place. Following the quad sessions, a report outlining the results of the survey and action plan will be included in this report for a Board level discussion. No support is required of the Board at this stage.

14. CONCLUSION

This report has outlined locally and nationally agreed measures to monitor maternity and neonatal safety to inform the Board of Directors of present or emerging safety concerns and the work currently being undertaken to mitigate and address those risks.

In summary the report has identified the following issues to be addressed:

a. A Maternity specific information system is due to be launched in October 2024 this has been identified as a barrier to progressing improvements at pace. A full paper-based end to end maternity record (handheld record) is in place, this will facilitate a complete pregnancy history for clinicians to risk assess and plan care safely.
b. Three Year Delivery Plan for Maternity and Neonatal Services has been published and work is underway to integrate with the Maternity Improvement Plan.
c. The PMRT historical cases are now being prioritised with a revised completion date of all cases by October 2023.

d. Training compliance is still below 90% a plan is in place to improve attendance, with a particular focus on Obstetric Emergency Drills (PROMPT) and Fetal Monitoring.
e. CNST Year 5 and SBLCBv3 have now been released and are being analysed. All of the requirements of CNST Year 5 are known however the SBLCBv3 toolkit outlining the audit requirements has yet to be released.

APPENDIX 1

Trust: Sheffield Teaching Hospitals NHS Foundation Trust 2023/24

CQC Maternity Ratings 2022	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
Jessop Wing	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

Maternity Safety Support Programme	Select Y / N	**Yes**

	April	**May**										
1.Findings of review of all perinatal deaths using the real time data monitoring tool	Section 2	Section 2										
2. Findings of review of all cases eligible for referral to HSIB	Section 3.1	Section 3.1										
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	Section 3.6	Section 3.6										
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Section 5	Section 5										
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	section 9	Section 9										
3.Service User Voice Feedback	Section 10	Section 10										
4.Staff feedback from frontline champion and walk-abouts	Section 7	Section 7										
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	None	None										
6.Coroner Reg 28 made directly to Trust	None	None										
7.Progress in achievement of CNST 10	Year 4 submitted	Section 6										

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Reported annually
9.Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	Reported annually

APPENDIX 2

Dashboard CHART

Antenatal	Green	Amber	Red	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Community First Visits				569	569	529	622	560	654	517	562
Community First Visits Within 10 Weeks %	$n \geq 90$	$75 \leq n < 90$	$n < 75$	71.88	72.41	71.08	68.97	72.86	71.41	70.99	72.95
Smokers at Community First Visit %	$n \leq 6$			7.38	13.01	9.83	7.56	7.5	8.1	9.09	7.3
Clinic First Visits				454	530	477	548	473	604	486	555
Clinic First Visits Under 13 Weeks %				66.3	63.96	68.34	61.5	65.12	65.89	60.91	61.62
Clinic First Visits Smoker %	$n \leq 6$			11.23	7.55	11.32	8.21	8.03	8.44	11.32	8.83
Clinic First Visits CO Measured %				69.38	52.45	46.75	53.47	72.73	81.95	85.8	86.67
Clinic First Visits CO ≥ 4ppm				12.38	8.99	8.07	7.85	9.01	5.45	6.71	7.28
Community 36 Week Visits CO Measured %				65.06	68.86	69.23	68.88	65.4	79.21	84.08	82.04
Community 36 Week Visits CO ≥ 4ppm				9.17	13.69	9.33	12.97	11.17	10.99	10	8.5
CO reduced below 4ppm by 36 weeks %				0	23.08	38.89	27.27	35.29	33.33	35	18.75

Deliveries	Green	Amber	Red	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Total Deliveries (mothers)				469	465	470	434	409	480	407	483
Registerable Births				473	469	474	437	413	480	413	492
Elective C Section Deliveries %				15.78	14.19	15.53	16.82	20.05	19.38	17.44	18.01
Emergency C Section Deliveries %				18.98	27.1	25.74	27.19	25.92	23.54	20.15	25.05
Assisted Deliveries %				14.07	14.19	11.49	12.21	7.33	10	11.79	13.46
Inductions %	$n \leq 32.8$			26.44	27.74	27.02	29.72	31.78	31.25	29.48	29.61
Waterbirths				14	22	14	8	15	11	12	15
Homebirths				5	11	5	1	2	2	5	7
Born Before Arrival (BBA)				8	3	6	5	2	5	3	5
APGAR 0-6 %				2.56	2.85	2.59	4.43	2.87	2.53	2.75	2.73
Low birthweight (≤ 2500g) %				9.51	9.17	10.76	12.36	6.54	10.62	10.17	9.96
Under 3rd Centile delivered at 38wks+ %									55.56	0	12.5
Singleton Livebirths < 30wks with $MgSO_4$ %				100	100	50	71.43	60	71.43	50	75
Preterm births %				5.51	7.49	6.4	7.91	5.21	6.25	9	6.2
Singleton births 16w - 23+6 %				0.65	0.87	1.3	1.64	0.25	1.48	0.75	0.42
Singleton births 24w - 36+6 %				5.87	7.21	6.72	8.22	4.95	6.55	8.71	6.75
PPH ≥ 1500ml %	$n < 3$	$3 \leq n \leq 5$	$n > 5$	3.65	3.25	3.43	3.5	2.69	5.7	2.95	4.99

3rd and 4th degree tears (all) %				6.55	1.99	5.18	4.04	0.95	5.2	4.27	4.63
3rd and 4th degree tears (Normal) %	$n < 3$	$3 \le n \le 4$	$n > 4$	5.7	1.57	4.46	2.81	0.55	4.85	4.19	3.98
3rd and 4th degree tears (Assisted) %	$n < 5$	$5 \le n \le 9$	$n > 9$	9.68	3.33	8.16	8.89	3.45	6.82	4.65	6.9
Smokers At Delivery %	$n \le 6$			6.87	8.66	11.59	9.32	9.05	7.17	9.58	8.52
First Feed Breastmilk %	$n \ge 75$	$70 \le n < 75$	$n < 70$	71.22	74.46	66.81	65.74	72.57	70.71	69.34	71.11
Robson Group 1 having LSCS %				12.77	21.05	22.89	19.44	32.76	18.18	13.51	22.37
Robson Group 2 having LSCS %				47.92	59	64.29	70.65	63.64	60.19	57.97	59.05
Robson Group 5 having LSCS %				77.94	84.75	77.63	73.68	87.14	81.33	80.88	78.26
VBAC (Local) %				19.75	16	22.34	26.76	12.99	20.69	19.75	19.77
VBAC (NHSD) %				18.42	13.33	14.29	32.43	7.69	14.58	20	17.78

Neonatal	Green	Amber	Red	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Neonatal Unit Admissions				39	44	39	44	28	43	43	45
Neonatal Unit Admissions %				8.32	9.44	8.3	10.19	6.8	9	10.46	9.22
Neonatal Unit Admissions at Term				21	17	17	19	16	21	19	23
Neonatal Unit Admissions at Term %				4.48	3.65	3.62	4.4	3.88	4.39	4.62	4.71

Mortality	Green	Amber	Red	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Stillbirths				4	3	4	5	1	2	2	4
Stillbirths ‰ (per thousand)	$n \le 2.55$			8.46	6.4	8.44	11.44	2.42	4.17	4.84	8.13
Stillbirths at Term				1	1	0	0	1	0	0	1
Stillbirths at Term ‰ (per thousand)				2.11	2.13	0	0	2.42	0	0	2.03
Feticide (Stillbirth)				0	0	1	1	0	1	0	2
Stillbirths excluding feticide ‰ (per thousand)				8.46	6.4	6.33	9.15	2.42	2.08	4.84	4.07
Neonatal Deaths				1	3	4	3	1	2	7	
Neonatal Deaths ‰ (per thousand)	$n \le 1.45$			2.13	6.44	8.51	6.94	2.43	4.18	17.03	
Neonatal Deaths ≥ 24 weeks				1	2	1	1	0	1	2	
Neonatal Deaths ≥ 24 weeks ‰ (per thousand)				2.13	4.29	2.13	2.31	0	2.09	4.87	
Neonatal Deaths at Term				0	0	0	0	0	0	0	
Neonatal Deaths at Term ‰ (per thousand)				0	0	0	0	0	0	0	

LW Assessment	Green	Amber	Red	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23

Calls to Triage Service				2749	2863	2909	2548	2459	2938	2730	2911
LWAU Admissions				1066	1124	1175	964	961	1168	1088	1214
LWAU Rapid Reviews %	$n \geq 95$	$80 \leq n < 95$	$n < 80$	96.81	96.98	97.02	96.99	96.57	97.69	97.61	97.94
LWAU Rapid Review Time (mins)	$n \leq 15$	$15 < n \leq 30$	$n > 30$	29	22	29	16	14	18	15	15

Other	Green	Amber	Red	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Readmissions				21	24	16	14	8	14	17	27